SENATE BILL No. 122

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-28-17; IC 27-13-10-8.

Synopsis: Grievance appeals. Provides that, unless an individual appealing a denial of reimbursement for covered health care services grants an extension of time for an accident and sickness insurer or a health maintenance organization to resolve the appeal, the appeal is automatically resolved in favor of the individual.

Effective: July 1, 2003.

Gard

January 7, 2003, read first time and referred to Committee on Health and Provider Services.

Introduced

First Regular Session 113th General Assembly (2003)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2002 Regular or Special Session of the General Assembly.

SENATE BILL No. 122

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-28-17, AS AMENDED BY P.L.1-2002, SECTION 116, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 17. (a) An insurer shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:

(1) Written or oral acknowledgment of the appeal not more than five (5) business days after the appeal is filed.

(2) Documentation of the substance of the appeal and the actions taken.

(3) Investigation of the substance of the appeal, including any aspects of clinical care involved.

(4) Notification to the covered individual:

(A) of the disposition of an appeal; and

(B) that the covered individual may have the right to further remedies allowed by law.

(5) Standards for timeliness in:

(A) responding to an appeal; and

(B) providing notice to covered individuals of:

(i) the disposition of an appeal; and

(ii) the right to initiate an external grievance review under IC 27-8-29;

that accommodate the clinical urgency of the situation.

(b) In the case of an appeal of a grievance decision described in section 6(1) or 6(2) of this chapter, an insurer shall appoint a panel of one (1) or more qualified individuals to resolve an appeal. The panel must include one (1) or more individuals who:

(1) have knowledge of the medical condition, procedure, or treatment at issue;

(2) are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;

(3) are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and

(4) do not have a direct business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

(c) An appeal of a grievance decision must be resolved:

(1) as expeditiously as possible, reflecting the clinical urgency of the situation; and

(2) not later than forty-five (45) days after the appeal is filed, **unless the covered individual grants an extension.**

If the covered individual does not grant an extension under subdivision (2) and the appeal is an appeal of a denial of reimbursement for a service covered under the accident and sickness insurance policy, the appeal must be resolved not later than forty-five (45) days after the appeal is filed, or the appeal is automatically resolved in favor of the covered individual.

(d) An insurer shall allow a covered individual the opportunity to:

(1) appear in person before; or

(2) if unable to appear in person, otherwise appropriately communicate with;

the panel appointed under subsection (b).

(e) An insurer shall notify a covered individual in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing the investigation. The appeal resolution notice must include the following:

(1) A statement of the decision reached by the insurer.

(2) A statement of the reasons, policies, and procedures that are the basis of the decision.

(3) Notice of the covered individual's right to further remedies allowed by law, including the right to external grievance review by an independent review organization under IC 27-8-29.

(4) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.

SECTION 2. IC 27-13-10-8, AS AMENDED BY P.L.133-1999, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 8. (a) A health maintenance organization shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:

(1) Acknowledgment of the appeal, orally or in writing, within three (3) business days after receipt of the appeal being filed.

(2) Documentation of the substance of the appeal and the actions taken.

(3) Investigation of the substance of the appeal, including any aspects of clinical care involved.

(4) Notification to enrollees or subscribers of the disposition of the appeal and that the enrollee or subscriber may have the right to further remedies allowed by law.

(5) Standards for timeliness in responding to appeals and providing notice to enrollees or subscribers of the disposition of the appeal and the right to initiate an external appeals process that accommodate the clinical urgency of the situation.

(b) The health maintenance organization shall appoint a panel of qualified individuals to resolve an appeal. An individual may not be appointed to the panel who has been involved in the matter giving rise to the complaint or in the initial investigation of the complaint. Except for grievances that have previously been appealed under IC 27-8-17, in the case of an appeal from the proposal, refusal, or delivery of a health care procedure, treatment, or service, the health maintenance organization shall appoint one (1) or more individuals to the panel to resolve the appeal. The panel must include one (1) or more individuals who:

(1) have knowledge in the medical condition, procedure, or treatment at issue;

(2) are in the same licensed profession as the provider who proposed, refused, or delivered the health care procedure, treatment, or service;

(3) are not involved in the matter giving rise to the appeal or the previous grievance process; and

(4) do not have a direct business relationship with the enrollee or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

(c) An appeal of a grievance decision must be resolved as expeditiously as possible and with regard to the clinical urgency of the appeal. However, an appeal must be resolved not later than forty-five (45) days after the appeal is filed, **unless the enrollee or subscriber grants an extension. If the enrollee or subscriber does not grant an extension under this subsection and the appeal is an appeal of a denial of reimbursement for a service covered under the individual contract or the group contract, the appeal must be resolved not later than forty-five (45) days after the appeal is filed, or the appeal is automatically resolved in favor of the enrollee or subscriber.**

(d) A health maintenance organization shall allow enrollees and subscribers the opportunity to appear in person at the panel or to communicate with the panel through appropriate other means if the enrollee or subscriber is unable to appear in person.

(e) A health maintenance organization shall notify the enrollee or subscriber in writing of the resolution of the appeal of a grievance within five (5) business days after completing the investigation. The grievance resolution notice must contain the following:

(1) The decision reached by the health maintenance organization.

(2) The reasons, policies, or procedures that are the basis of the decision.

(3) Notice of the enrollee's or subscriber's right to further remedies allowed by law, including the right to review by an independent review organization under IC 27-13-10.1.

(4) The department, address, and telephone number through which an enrollee may contact a qualified representative to obtain more information about the decision or the right to an appeal.

SECTION 3. [EFFECTIVE JULY 1, 2003] **(a) IC 27-8-28-17 and IC 27-13-10-8, both as amended by this act, apply to an appeal of a grievance that is filed after June 30, 2003.**

(b) This SECTION expires June 30, 2006.